Children with Special Health Care Needs
Adult Autism Treatment Account (AATA)
PO Box 144610
Salt Lake City UT 84114-4610
385.310.5238
aata@utah.gov

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Authorization to release the protected health information OF:

Patient Name:

Date of Birth:

To RELEASE protected health information FROM:
Name: Phone Number: Address: City, State, Zip:

To RELEASE protected health information TO:
Name: **Utah Department of Health, Adult Autism Treatment Account** Phone Number: **(385) 310-5238** Address: **PO Box 144610, Salt Lake City, UT 84114-4610** Email: **aata@utah.gov**

By signing below, I understand that:

1. This consent remains effective for **10 years** from the date last signed.
2. I may revoke this authorization at any time by giving written notice. Any actions already taken in reliance on this authorization will not be affected by my revocation.
3. Treatment, payment, enrollment in a health plan, or eligibility for benefits may not be conditioned on whether I sign this authorization. If an exception applies, the consequences to me will be explained.
4. I understand once the information is disclosed, this facility cannot guarantee that the Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
5. I may make a request in writing at any time to inspect and/or obtain a copy of the protected health information maintained at this facility to be used or disclosed as provided in the Federal Privacy Rule 45 CFR § 164.524.

Print Name of Patient or Legal Representative:	Date:
Signature of Patient or Legal Representative:	If signed by Legal Representative, Authority:

For questions regarding the disclosure of health information contained in this release, please contact:

The Adult Autism Treatment Account (385) 310-5238